POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER H-01	PAGE NUMBER 1 OF 2
	RELATED NCCHC/ACA STANDARDS: P-H-01/4-4413 (ESSENTIAL)	
CHAPTER: 11 HEALTH SERVICES	**SUBJECT:** HEALTH RECORD FORMAT AND CONTENTS	
APPROVED BY THE COMMISSIONER:		
EFFECTIVE DATE: 11-19-07		

PURPOSE: A method of recording entries in the health record and the format of the health record are approved by the Office of Health Services. This will be the combined medical/mental health chart.

POLICY:

A health record is initiated for an inmate at the time of *initial* intake receiving screening.

1. A health record contains at a minimum these elements:

   a. Identifying information (e.g., name, SBI number, date of birth, gender);

   b. Problem list with significant current medical and mental health diagnosis, chronic illnesses, known significant past medical and mental health problems, and known allergies. This form will be kept in the front of the second section of the medical chart.

   c. Receiving screening and health assessment documentation.

   d. Progress notes of all significant findings, diagnoses, treatments and dispositions.

   e. Orders for prescribed medications and medication administration records.

   f. Reports of laboratory, x-ray and diagnostic studies when available.

   g. Flow sheet documentation.

   h. Consent and refusal forms documentation.

   i. Release of information documentation.

   j. Discharge summary of hospitalizations and other inpatient stays when available.

   k. Reports of specialty consultations and off site referrals which includes, at a minimum, diagnostic findings and treatment recommendations.

l. Special Needs Treatment plans.

m. Documentation of Chronic Care Clinic visits.

n. Immunization records and communicable disease history and testing.

o. Infirmary care records or summary of care.

3. Each encounter for health care is documented in the problem oriented SOAP format, is legible and contains the time, date, and place of the encounter and the signature of the documenter.

4. All documentation in the health record contains a date and time of the documentation and the signature of the documenter.

5. The health record is identified with the inmate/patient's name, SBI number and date of birth. Each page of the health record contains inmate/patient-identifying information (at minimum name and SBI number).

6. Only approved forms and format are used.

7. If electronic records are used, the need for hard copy back up is addressed.

8. Mental health and dental information are included in the medical record.

References:

National Commission on Correctional Mental Health Care: Standards & Guidelines for Delivering Services, 2003, M-H-01.

American Correctional Association: Standards for Adult Correctional Institutions, 4th Edition January 2003. 4-4375